DOCUMENT RESUME

ED 357 528 EC 302 070

AUTHOR	Harbin, Gloria L.; And Others
TITLE	Service System Coordination under Part H of IDEA: A National Survey Report.
INSTITUTION	North Carolina Univ., Chapel Hill. Carolina Inst. for Child and Family Policy.
SPONS AGENCY	Special Education Programs (ED/OSERS), Washington, DC.
PUB DATE	Mar 93
CONTRACT	G0087C3065
NOTE	61p.
PUB TYPE	Reports - Research/Technical (143)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	*Agency Cooperation; Compliance (Legal); *Delivery Systems; *Disabilities; *Educational Legislation; *Federal Legislation; Infants; Policy Formation; Preschool Children; Services; *State Programs; Young Children
IDENTIFIERS	*Individuals with Disabilities Education Act Part H

ABSTRACT

This report presents the methodology and findings of a survey of state coordinators implementing Part H of the Individuals with Disabilities Education Act. The survey, conducted to examine the nature and scope of interagency coordination efforts, was completed and returned by 38 coordinators. Nine areas of coordination are addressed: major coordination goals, age range targeted for coordination, development of the vision for a coordinated service system, agencies involved, structure used, policies, staffing, accomplishments, and state evaluation efforts. Findings indicated that: (1) coordinators viewed the purposes of coordination from a broad perspective; (2) 70 percent of the states were only coordinating services for ages 0-3; (3) the mean number of agencies involved in service coordination was 4.8; (4) 78 percent used a group of directors to develop Part H policies; (5) most states had developed one or two interagency agreements; (6) mean number of full time staff was 5.7; (7) 13 areas of progress were identified; and (8) 17 states were involved in evaluating service coordination. (Contains 36 references.) (DB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED357528

Carolina Institute for Child and Family Policy

SERVICE SYSTEM COORDINATION UNDER PART H OF IDEA: A NATIONAL SURVEY REPORT

Gloria L. Harbin
Richard Clifford
Kathleen Bernier

The University of North Carolina at Chapel Hill

EC 302070

SERVICE SYSTEM COORDINATION UNDER PART H OF IDEA: A NATIONAL SURVEY REPORT

Gloria L. Harbin
Richard Clifford
Kathleen Bernier

MARCH, 1993

Carolina Policy Studies Program
137 E. Franklin Street, 300 NationsBank Plaza
Chapel Hill, NC 27514

Carolina Policy Studies Program is funded by the Office of Special Education Programs, U.S. Department of Education, Cooperative Agreement #G0087C3065. However, these contents do not necessarily represent the policy of the Department of Education, and you should not assume endorsement by the Federal Government.

TABLE OF CONTENTS

I. **List of Tables and Figures** ii

II. **Acknowledgements** iii

III. **Executive Summary** iv

IV. **Introduction** 1

V. **Purpose** 3

VI. **Methodology** 3
- Survey Development 3
- Survey Mailing and Follow-up 4
- Survey Analysis 5
- Limitations of the Study 6

VII. **Results** 7
- Goals for Coordination Effort 7
- Age Range Targeted for Coordination 9
- Development of the Vision for the Coordinated System 11
- Who is Involved in Coordination of Services? 14
  - Number of Agencies 14
  - Number of Programs and Divisions 17
  - Number of Agencies Providing Each Service 18
  - Use of Private Providers 20
- Structures and Mechanisms Used for Coordination 20
  - Lead Agencies' Role in the Approach to Decision Making 22
  - Use of Formal Liaisons Between Part H and Other Agencies 23
  - Use of Policy Group of Mid-Level Managers 24
  - Use of an Intra-Agency Work Group 25
  - Local Lead Agency 26
- Policies Related to Service Coordination 26
  - Interagency Agreements 26
  - Number of Signatories 28
  - Status of Local Interagency Agreements 28
  - Effect of Part H on Policies for Other Related Programs 29
  - Role of Private Health Sector 31
- Number of Individuals Officially Designated to Work on Part H Activities 33
  - Financial Support for Staff 34
- Accomplishments in the Area of Service Coordination Efforts 36

VIII. **Summary and Conclusions** 37

IX. **References** 45

TABLES AND FIGURES

Table 1. Priority ranking of coordination goals by 34 respondents 8

Table 2. Age range for which services are coordinated, by state 10

Table 3. Lead agency in states with birth to five systems 11

Table 4. Leadership source identified by state respondents 13

Figure 1. Number of agencies involved in coordinating services 16

Table 5. Agencies identified in coordination efforts by state respondents 17

Table 6. Number of state agencies coordinating services 19

Figure 2. Use of private providers to provide early intervention services in rural and urban areas 21

Table 7. Decision-making approaches of responding states 22

Table 8. Assignment or location of liaison for coordination 24

Table 9. Composition of intra-agency work groups 25

Table 10. Number of interagency agreements in responding states 28

Table 11. Status of local interagency agreements in responding states 29

Table 12. Effect of Part H on policies in other programs 30

Table 13. Participation level of various private health entities in Part H coordination 32

Table 14. Rank order involvement in Part H of private health entities, based on % of responding states rating involvement as moderate or extensive 33

Figure 3. Staff for Part H 35

ACKNOWLEDGEMENTS

The authors wish to thank four Part H coordinators who greatly contributed to the development of the survey instrument. Duncan Munn, Mary Elder, Karl Kastorf, and Chris Kaminsky graciously and generously agreed to pilot the survey and provided comments which guided revisions. We also appreciate that Part H Coordinators from 38 states gave willingly of their time to complete this difficult and lengthy questionnaire.

We also wish to thank Elizabeth Gunn who ably conducted many of the analyses of the data, and kept us always aware of the need for care and precision in interpreting the findings. CPSP Director, James Gallagher, provided valuable feedback to us at every stage of the project. Beverly Johnson and Geraldine Burt also deserve thanks for their assistance in the production of this document through its many drafts.

The authors especially appreciated the significant contributions of Carol Berman. Her suggestions regarding complex conceptual issues were instrumental in the interpretation of the data and the resulting conclusions.

Even with all of this help we are sure to have made mistakes. We take full credit for these, as well as for the interpretations of the data as reported in this document.

EXECUTIVE SUMMARY

The implementation of Part H of the Individuals with Disabilities Education Act (IDEA) has presented a number of challenges to state governments. Foremost among these has been the federal requirement that services to children with disabilities be coordinated. Historically, because of a number of barriers, interagency service coordination has not been accomplished easily. Previous case studies in six diverse states indicated variation in both the **scope** and **nature** of service coordination (Harbin & Terry, 1991).

In an attempt to determine if these case study findings were applicable nationwide, this study was designed to survey Part H Coordinators in each state and the District of Columbia, in order to determine the nature and scope of state interagency coordination efforts; a companion report (Clifford, Bernier, & Harbin, 1993) details results from a section of the survey concerned with the financing of Part H services. Thirty-eight (75%) Part H Coordinators completed and returned the survey; no substantial differences were found between the group of responding and non-responding states regarding the amount of progress in implementing Part H, type of Lead Agency, or on various traditional demographic variables. All states were in at least their second year of implementing Part H services.

Nine areas relating to the **scope** and **nature** of coordination are addressed in this report. These include: (1) major goals for the coordination effort; (2) age range targeted for coordination; (3) development of the vision for a coordinated service system; (4) who is involved in the coordination of services; (5) the structure used for service coordination; (6) policies related to service coordination; (7) number of individuals designated to work on Part H activities; (8) accomplishments in the area of service coordination; and (9) state evaluation of service coordination efforts.

The lengthy and complex survey yielded many results which are presented and discussed in the body of the full report. Some of the major findings are presented below.

GENERAL

- Principal findings from the study attest to the widespread commitment of personnel in agencies throughout the country in implementing Part H of the IDEA. Contrary to concerns that states might merely provide lip service to coordinators, these findings indicated that those responsible for the task were taking the charge included in the federal legislation to coordinate services very seriously.

GOALS

- Although primary interagency coordination goals vary from state to state, Part H Coordinators, overall, view the purposes of coordination from a broad perspective. Many states indicated that they were coordinating with other relevant programs (e.g.. EPSDT, etc.); many were coordinating efforts to serve at-risk children, and still other states were incorporating Part H into a wider initiative for all young children.

AGE RANGE

- Over seventy percent of the states responding were only coordinating services for children from birth to age three. Designation of the lead agency (i.e., Education, Human Services/DD, etc.) was not generally correlated with the age range of children targeted for coordinated service delivery.

VISION

- Most Part H Coordinators (76%) did not designate a specific individual or group as <u>most important</u> in developing the vision of the Part H service

system. Instead, they indicated that in addition to the Part H staff the parents, service providers, regional or local Interagency Coordinating Councils (ICCs), and contractors or consultants all shared in devising a coordinated system.

INVOLVEMENT

- The mean number of agencies involved in service coordination was 4.8 state agencies. The scope of coordination becomes even broader when the number of agency subdivisions or programs were also included. The mean number of state programs involved in the efforts to coordinate services was 10.35.
- A different way of understanding the sope of coordination examined the number of agencies involved in each major type of service. Generally, states reported that more agencies (three or four) were involved with systems entry activities, such a child find and public awareness, than with coordinating developmental intervention, individualized planning, and therapeutic services. The least number of agencies were involved in coordinating mental health care.
- States will be relying heavily upon private providers to provide therapies (i.e. speech/language, occupational, physical), as well as audiological and mental health services.

STRUCTURES

- States are using a variety of structures and mechanisms to facilitate the coordination of services across agencies. Over 65% of the responding states had persons designated to act as a liaison between Part H and the activities of various other programs.

- The majority of responding states (78%) utilized a group of division directors (e.g. Directors of Special Education, Maternal and Child Health, etc.) to develop and negotiate policies related to Part H. In addition, 70% of responding states had created intra-agency work groups to facilitate service coordination in larger agencies.
- A surprising number (60%) of responding states allowed communities to designate lead agencies at the local level.

POLICIES

- States continue to make progress in developing interagency agreements. At the time of this survey, most of the states responding had developed one or two interagency agreements at the state level; the mean number of individuals signing the agreements was 3.77. Most states were also encouraging local agreements.
- Results indicated that the process of Part H policy development had effected the policies of other relevant programs. Surprisingly, 57% of responding states were actually changing their policies to be more complimentary with Part H early intervention policies.

STAFF

- The number of individuals officially designated to work on Part H activities varied considerably from state to state, ranging from 1 to 45. The mean number of full time staff persons was 5.7, and the mean number of part time staff persons was 2.6.

IMPROVEMENTS

- Most reporting states (63%) indicated that progress was being made in various aspects of interagency service coordination. States listed 13 areas in which progress had occurred.
- Surprisingly, 17 states revealed that they were involved in evaluating service coordination at the state and/or local level.

Taken together, these results reveal the widespread commitment of agency personnel nationwide to the implementation of Part H of the IDEA. Goals related to service system coordination are comprehensive; in addition, many agencies, programs, and service providers have been involved in the development of the policies and processes related to service coordination. In general, findings from this study indicate that state policymakers, parents, and providers have made substantial progress in meeting both the letter and intent of this legislation as they have developed broad-based, comprehensive approaches to coordination.

INTRODUCTION

Part H of the Individuals with Disabilities Education Act (IDEA) has often been described as revolutionary legislation. One of the foremost challenges within this legislation is the requirement for coordinated services. The fragmented and inaccessible nature of service delivery for young children with special needs and their families has been well-documented in the literature (Brewer & Kakalik, 1979; Gans & Horton, 1975; Meisels, Harbin, Modilgiani & Olson, 1988). Part H of IDEA requires participating states to bridge the partitions between state agencies in order to remedy this fragmentation and lack of coordination.

Despite the widespread acceptance of the need for interagency service coordination, historically it has been difficult to achieve. The most frequently mentioned barriers to the coordination of services across agencies include: agency rigidity (Pollard, Hall, and Keeran, 1979), lack of leadership and involvement from high level decision-makers (Hayes, 1982), protection of turf (Christensen, 1982; Colby, 1987; Leach & Barnard, 1983), competition for financial resources (Colby, 1987), and conflicting state and federal policies (Harbin & McNulty, 1990; Steiner, 1976).

The Carolina Policy Studies Program (CPSP) conducted a two year case study of six states regarding multiple topics related to the implementation of Part H of the IDEA. These case studies indicated that these six states were approaching the task and challenges of service coordination differently (Harbin & Terry, 1991). Results of these studies indicated that the **scope of coordination** varied across states. Among these six states the scope of coordination ranged from extensive to minimal. For example, one state was attempting to coordinate all initiatives and programs for all young children in that state. Therefore, there were a large number of agency and private sector representatives working to develop a system of services for all children. However, at the other end of the continuum, another state focused

their coordination efforts toward developmentally delayed or disabled infants and toddlers only. There was very little effort to coordinate activities or policies with other programs or agencies. In the few instances where coordination occurred, it was usually with one other agency. States also differed as to the scope of the age range targeted for coordination. Some states were attempting to develop a "seamless" system for children birth through age five, while other states were designing two separate systems, one for children birth through age two and one for three through five year old children. Thus, these two types of states differed significantly in the scope of the population targeted for coordination, as well as the scope of agencies, programs, and people participating in coordination efforts and activities.

These case study states also differed considerably with regard to the **nature of coordination**. Some states had multiple public and private agencies participating in numerous activities and task forces, while other states were making very little use of task forces. Some states formally used Part H staff as liaisons to various key agencies and programs. Others did not create these formal organizational affiliations. Some states had a multi-leveled structure for coordinating activities at various state and local levels, while others had no such structure. Finally, the number of Part H staff members and members of other agencies working on Part H activities varied dramatically as well.

While Part H of the IDEA puts forth a single set of requirements, there was great diversity among the case study states with regard to the implementation of these requirements. Given the previous difficulties experienced by many states in earlier attempts at coordination, many parents, professionals and policymakers have actually questioned the feasibility of coordinating disparate programs across agencies (Weiss, 1981; Peterson, 1991; Martinson, 1982). Indeed, Peterson (1991) raises an even more provocative question when she asks"... can workable

interagency systems be planned, organized, and fully implemented in a short period and still enable collaboration to be successful and operable in the future?"

PURPOSE

All states participating in Part H of IDEA are required to coordinate services across agencies and providers. The purpose of this study was to describe both the **nature** and **scope** of coordination efforts at the state level, as a result of states participation in this monumental legislation. Given the difficulties in successful coordination, along with the widespread skepticism regarding its feasibility, a clearer picture of just how this complex concept is being implemented is critical.

METHODOLOGY

Survey Development

In order to obtain a descriptive portrait of both the coordination of services and finances, a three part survey was developed. Part I contained general information related to coordination. Part II of the survey addressed service coordination, while Part III focused on the financing of services

The finance-interagency survey items were created through a collaboration between CPSP staff studying financing issues and those studying interagency collaboration issues, and were designed to elicit information from Part H Coordinators in all 50 states and the District of Columbia. It was anticipated that results from the survey would be compared with hypotheses developed during the case studies and other CPSP research efforts.

The survey items were initially written by CPSP finance and interagency studies investigators Clifford and Harbin. These items were reviewed internally, and additions and changes made. A preliminary form of the survey was completed, using

both survey design research (Dillman, 1978) and formatting and design suggestions from data analysis consultants.

This preliminary form was then pilot tested with one Part H Coordinator, who provided valuable comments regarding the purpose of the survey, critiqued the survey item by item, and suggested item deletions and additions. These changes were incorporated into the survey, and a second pilot testing was conducted. Four Part H Coordinators from demographically diverse states were asked to complete and critique the survey. Their comments, in addition to a final internal review, led to production of the final form of the finance-interagency survey printed for distribution.

The Part H Coordinator who was involved with the first piloting process was asked to complete a new form of the final survey, in order that survey results from this state be comparable with other states. The Part H Coordinators involved in the second piloting of the survey were asked to update and clarify answers to any questions that had been edited or changed from their pilot version of the survey for the final version of the survey.

Survey Mailing and Follow-up

The surveys were mailed, with cover letters explaining the purpose of the survey, to the remaining 45 states and the District of Columbia at the beginning of June, 1991. A follow-up letter was mailed to non-responding states after another six weeks had passed. These processes resulted in the collection of thirty surveys (59% return rate). The responding states were compared with non-responding states, at this point, to determine if the two groups differed on amount of progress in implementing Part H, region of U.S., type of Lead Agency, and other demographic variables, such as wealth, population, and urban/rural distribution. There was a high degree of match between the groups of responding and non responding states.

One final attempt was made to increase the response rate for the final set of analyses. The survey was reformatted into a more compact booklet. This booklet, with a cover letter again requesting a response, was mailed to the remaining non-responding states. A final follow-up letter was sent one month later. The total survey response was 38, for a return rate of 75%. Appendix A displays the distribution of responding states based on a number of demographic variables, indicating a high degree of match between the final sample of states responding to the survey and the total population of states.

Survey Analysis

All statistical analyses were run using procedures in Statistical Analysis System (SAS), Version 6.04, from the SAS Institute, Cary, NC. The preliminary analysis of all items, consisting of descriptive statistics, including frequencies and percentages, was conducted after the receipt of 29 surveys. These preliminary findings were summarized in a Short Report disseminated only to responding states in January, 1992 (Clifford, Harbin, & Bernier, 1992).

The same descriptive analyses were rerun on the final data set. Further statistical analyses also were run on the final data set, which provided more detail for specific survey items and compared responses of groups of related items. Responses of the analyses are presented in the section below. Many of the responding states wrote comments about specific practices in their states on the returned surveys. These comments were summarized by item and carefully examined as the statistical analyses were conducted, to assure that interpretation of the results reflected the sense of the respondents. The comments were sometimes used in the text of this report to clarify the reporting of statistical findings.

Limitations of the study

Virtually all reports of the Carolina Policy Studies Program have made this disclaimer: study of Part H is a highly complicated endeavor. Part H implementation is such a moving target that even the calendar year cannot be stated with precision. It can be said that all states in this study were at least in their second year of Part H implementation at the time that the respondents completed this survey. Nonetheless, the precision of that statement is colored by the fact that a year can be defined as either twelve months or eighteen months, depending upon whether funding was extended under the Tydings provision. Part H coordination does not occur in isolation, and at the time of this study, new national initiatives, such as the Family Support Act and the Child Care and Development Block Grant, were enacted that may bear on the coordination of service delivery systems in the future.

Since the survey instruments were completed by Part H Coordinators, it is conceivable that respondents might have been inclined to embellish their states' coordination efforts, given their position of responsibility and stake in the program. On the other hand, it is equally arguable that respondents might have underplayed their states' achievements out of modesty. We felt confident in the objectivity of responses, partly because we have conducted numerous surveys with this group, and have established a relationship of trust, and partly because our findings were substantiated by internal consistency.

RESULTS

The **scope** and **nature** of coordination in those states responding to the survey will be described by addressing nine areas of study: (1) goal for coordination effort; (2) age range targeted for coordination; (3) development of vision for a coordinated service system; (4) who is involved in the coordination efforts; (5) the structure used for coordination; (6) policies related to coordination; (7) number of individuals designated to work on Part H activities; (8) accomplishments in the area of service coordination; and (9) state evaluation of coordination efforts.

It is important to note at the outset of this section that the number of respondents differ across survey items, because in some instances one or more of the states either forgot to answer a question or chose not to do so.

Goals for Coordination Effort

Our study sought to relate the scope of coordination to several factors, including size of population to be served, breadth of services, and numbers and kinds of programs involved in coordination. We described major coordination goals, arranged along a continuum as to scope of coordination, from narrow to broad, and asked respondents to assign priority rankings. The continuum of goals included:

A. Coordinating a single aspect or a few aspects of the program (e.g. transition, child find, integration into child care) for developmentally delayed infants and toddlers;

B. Once again, coordinating a single aspect or a few aspects of service delivery, but for both developmentally delayed and at risk infants and toddlers;

C. Coordinating intervention programs for various sub-populations of developmentally delayed infants and toddlers (e.g., hearing impaired, etc.) which are provided by different lead agencies;

D. Increasing coordination efforts to include additional services provided by programs such as EPSDT, Children s Medical Services, WIC, etc.

E. To coordinate a large variety of services for both developmentally delayed and at risk infants and toddlers; and

F. Incorporating Part H as part of a wider initiative for all young children in the state.

In addition to the six options from which participants could select, the questionnaire permitted selection of a goal or goals that might have been overlooked in the continuum.

We found that primary goals for coordination varied from state to state, as might be expected given the diversity of states' history, structure of service provision, and agency leaders vision of a coordinated service system. Table 1, which follows, displays the relative ranking of each coordination goal, by indicating the number of respondents who identified the goal as a first or second priority for his or her state Part H effort. The letters listed under Goal in the following table correspond to the goals described above.

Table 1. Priority Ranking Of Coordination Goals By 34 Respondents

Goal	1st priority	2nd priority
A	3	2
B	1	1
C	1	4
D	7	9
E	14	4
F	8	10

It can be seen that modal responses were for goals (D), (E) and (F). Only three states selected as their highest priority the relatively narrow description, (A) in which a single aspect or a few aspects of service provision were targeted for coordination. Only one state selected (C), whereby developmental intervention programs were coordinated for specific disability subpopulations. Seven states were coordinating services with other related programs for developmentally delayed - a broader goal (D). Twenty-two states reported, as a top priority, coordinating services for developmentally delayed and at risk children (E), or incorporating Part H into a wider initiative (F), an even broader goal. Category (B), similar to (A) except that at risk infants and toddlers were included, was the coordination approach selected by the fewest states.

Findings suggested that, at least in the view of the state Part H Coordinators, the purposes of coordination were broad. Contrary to concerns that states would merely provide lip service to coordination requirements, making little effort and keeping the scope of coordination a narrow, and therefore, manageable task; these findings indicated that those responsible for the task were taking the charge included in the federal legislation to coordinate services seriously.

A distinction can be made between coordination efforts and eligibility policy. Many states reported including at risk children in their coordination efforts, despite the fact that at the time of the study, only 12 of the 38 states in this study included at risk children in their eligibility policy.

Age Range Targeted for Coordination

Part H of the IDEA requires coordination of services for eligible children birth through two years of age. Having differing sets of requirements for the Infant-Toddler and Preschool programs has been an issue among individuals concerned with

continuity of services. Therefore, we were interested to learn for what age ranges services were to be coordinated. Table 2 displays results.

Table 2. Age Range For Which Services Are Coordinated, By State

Age Range	Number of States
0-3	26
0-5	10
0-6	1
0-8	0

Twenty-six, or 70.3% of states responding to the survey were coordinating services for the birth to three population only. Since all states were participating in Part H, and therefore included the birth to three population in their coordination efforts, the options of 3-5, 3-6, or 3-8 alone, were not included in the questionnaire.

One might speculate that where the State Department of Education has agreed to be the lead agency for Part H, there might be a built-in incentive to select the birth to five age range as the target for coordinated services, since it would permit a seamless system from early intervention services under Part H of the IDEA into the preschool program under Part B. It would appear that, if both programs (infant-toddler and preschool) were in the same lead agency, it might be easier to write one eligibility policy and design one service system, since only one lead agency would have to agree to a single policy for both age ranges. On the other hand, it is arguable that an Education lead agency might choose to have differing eligibility requirements for the two programs in order to limit the population for one of the programs. In which case, a seamless system would not be the goal of this agency.

A summary is provided in Table 3, which shows that in general the lead agency designation was of no consequence in predicting whether or not states selected a birth to five age range as the target for their coordinated system.

Table 3. Lead Agency For Part H States With Birth To Five Systems

Locus of Lead Agency	# States responding to survey	# respondents with birth to five system
Education	13	3
Human Services/DD	15	4
Health	7	2
Interagency	2	1
Governor s Office	1	0

We found that, of the 10 states creating a birth to five system, three had designated the State Department of Education as the lead agency for Part H. The probability for this age range to be the target population for coordination was roughly equal among various types of lead agencies. The reader is cautioned to remember that these results were obtained from a sample of states and not the entire population. However, we thought that these results were worth presenting, since they are contrary to what one might expect. It appears that despite all of the difficulties, policymakers in some states are attempting to overcome various barriers to coordinate services for children birth through five years of age even though there are two different lead agencies for the two age groups.

Development of the Vision for the Coordinated Service System

The crafters of the law establishing Part H of the IDEA recognized that most states were plagued by a fragmented service system. A number of federally sponsored resources, such as the program for Children with Special Health Care Needs (CSHN), Early Periodic Screening, Diagnosis and Treatment (EPSDT), Head

Start, and Nutrition Supplements for Women, Infants and Children (WIC), had been designed as separate entities for categorically eligible populations. Sometimes the same children and families needing one type of program (e.g., EPSDT) were eligible for and needed various other types of services (e.g., WIC, CSHN).

A premise of this study was that if a coordinated system of these various disparate, categorical programs is to be a reality, someone has to have the ability to visualize what a coordinated system of services would look like at the state level, at the local level, and at the level seen by families - actual service provision. These visionaries need an understanding of multiple programs and agencies, as well as knowledge of the structure of state and local government, and of the current service system at these various levels.

We had known from our case studies (Harbin, Clifford, Gallagher, Eckland, & Place, 1991) that some individual or small core group of individuals provided the day to day leadership and vision in Part H system reform efforts. We wanted to explore in the present study whether individuals charged with administration of Part H (i.e., Part H Coordinators) would identify themselves and those with whom they were working in this capacity (i.e., Part H staff and/or Lead Agency Director). We asked respondents to rate only one individual or group as most important in the development of the vision of the Part H service system.

We found that respondents in only six states complied with this instruction. Four of these respondents indicated that the lead agency director was most important in the development of the vision for a coordinated service system; one respondent chose the ICC Executive Committee and one respondent chose a group of program administrators (e.g., Directors of Special Education, Developmental Disabilities, etc.) as most important. One respondent did not complete this question. The remaining twenty-nine respondents in our sample rated no one individual or

group as most important, but selected multiple individuals/groups as important, despite the instructions to the contrary.

When data were combined for all states and means were computed for each of the possible groups or types of individuals who might provide leadership in the development of a vision for a coordinated service system, results were as follows:

Table 4. Leadership Source Identified By State Respondents

Source of Leadership	Mean
Part H Coordinator	3.14
ICC	3.05
Task Forces	3.00
Part H Staff	3.00
ICC Chair	2.78
ICC Executive Committee	2.62
Group of Program Directors	2.62
Lead Agency Director	2.51
Other Parents Service Providers	 3.13 3.00

Results indicate that while many Part H Coordinators perceive themselves as providing a primary leadership, other individuals and groups also are seen in leadership roles. Respondents were given the opportunity to add additional groups or individuals that they considered as contributing to the development of the vision of this service system. It is interesting to note that there were four prominent responses: parents, service providers, regional or local ICCs, and contractors or consultants. We concluded that the vision is shaped by the participation of many. However, we

also feel that modesty is probably playing a role in the way this item was answered. For in our case study states, the Part H Coordinator and/or the Lead Agency Director were chiefly instrumental in developing the framework for the vision, while enlisting the participation of many groups and individuals in the process of putting meat onto the bones of the skeleton vision. The Part H Coordinators and/or the Lead Agency Directors in case study states were also instrumental in setting forth and making visible the values which were intended to undergird the system of services. There is no doubt that many individuals in each state have worked to help shape the vision of the service system. However, it is quite probable that the amount and the nature of contributions of individuals differ. Contrary to the results of this study, it seems more plausible that, in general, those individuals who are assigned to work on this task full time are going to be more influential than those individuals who can only contribute periodically.

Who is Involved in Coordination of Services?

At first thought, the description of who is involved in the coordination of early intervention services seems like a relatively simple undertaking. However, there are a variety of ways to approach this. This section addresses several aspects related to this issue: (a) the number of state agencies participating in the coordination of services; (b) the number of programs or divisions within each of these agencies; (c) the number of agencies providing various program functions (e.g., child find) and services (e.g., occupational therapy; and (d) the use of the private sector in the provision and coordination of services. Data from each of these areas are presented below.

Number of agencies. All agencies providing services to the target population have a stake in the coordination of services. Requirements of Part H call for a single lead agency, anticipating, however, that as many involved agencies as

possible would be included in coordination efforts. We wanted to know how many State-level agencies were instrumental in the coordination of early intervention services. We clarified our question to focus on coordination of services, not funding sources. We also permitted responses that would include statewide entities which are not formally part of state government such as Head Start, as well as non-public entities, such as State chapters of the Academy of Pediatrics. We specified that these entities must be formally and officially involved in policy development, approval and implementation.

We found the modal number of agencies involved was four to six (18 states). The number of agencies involved ranged from none (1 state) to 25 agencies (1 state). The mean was 4.8 agencies, with 78% of states involving 3 or more agencies. Results are displayed on Figure 1.

Following, in rank order named, were the agencies specifically identified by respondents (see Table 5). Unfortunately, a few respondents did not include the lead agency in their list of agencies involved in coordination. While this is the case for only 10% of the sample, these data should be viewed conservatively, since they under-report all agencies and the programs within those agencies included in coordination.

Not surprisingly, the principal state agencies that have been designated by Governors as lead agencies also are those most commonly involved in coordination within responding states. These include Departments of Education, Health, Human Resources, Social Services, and Developmental Disabilities/Mental Retardation. Moreover, as with agencies designated to be the lead for Part H, Departments of Health and Education were those most frequently identified.

Figure 1
Number of Agencies Involved In Coordinating Services

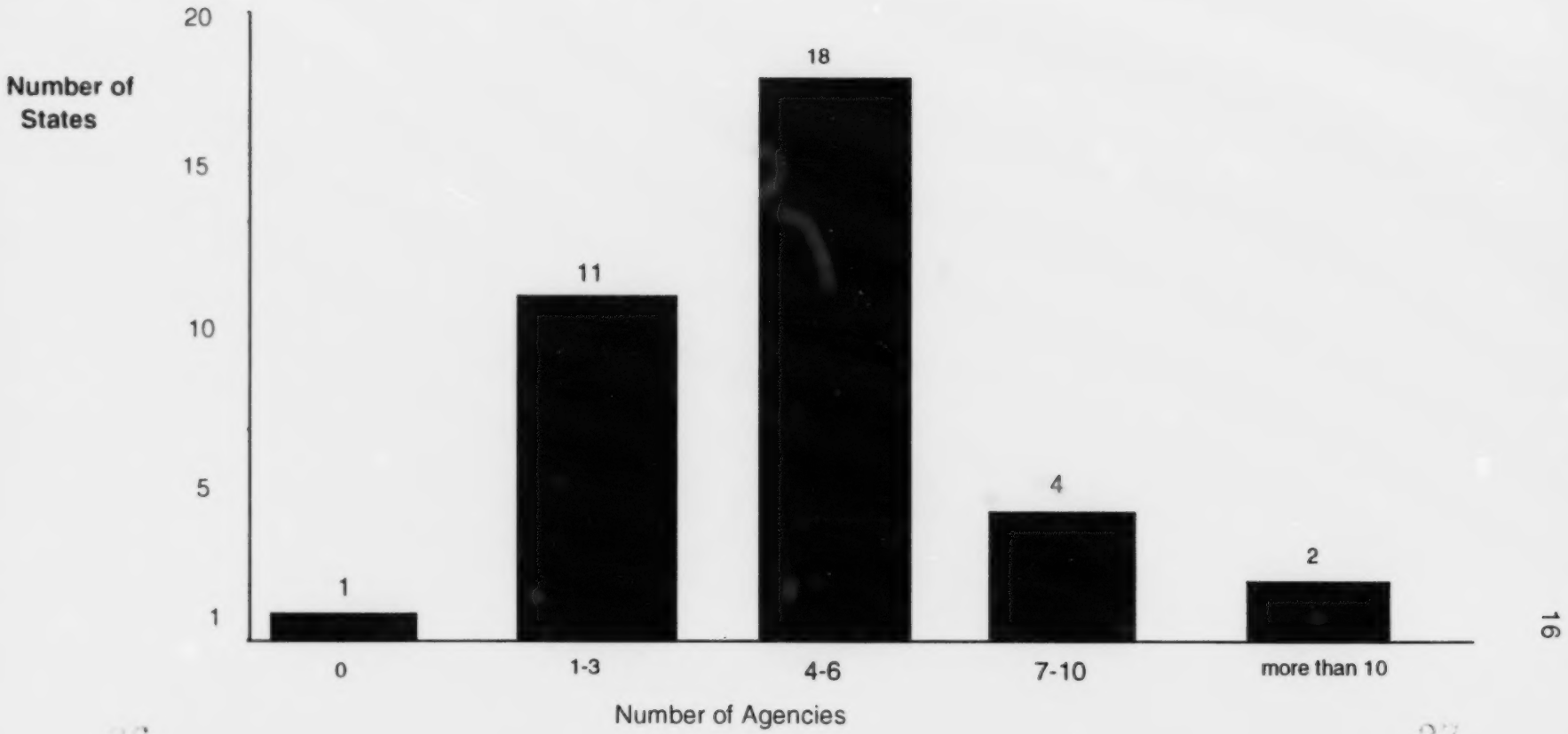


Table 5. Agencies Identified In Coordination Efforts By State Respondents

Agency	Number of States
Education	30
Health/Maternal Child Health	26
Human Resources	16
Social Services	12
-Community Services	2
-Children & Family Services	2
-Child Day Care Section	1
Institutions/Developmental Disabilities/Mental Retardation	10
Miscellaneous Agencies (Cooperative Extension, Department of Corrections, Juvenile Services, Probate Courts, District Health Departments, Economic Security, Rehabilitation Service, Transportation	8
Schools/Services for Deaf/Hard of Hearing and Blind/Visually Handicapped	7
Head Start	6
Miscellaneous programs/organizations (universities, service programs, NICU, neonatal associates, Child Development and Rehabilitation Center	5
Medical Assistance/Medicaid	4
Mental Health	4
DD Council	3
Governor s Office	3
University (UAP, Hospital, Medical School)	3
Alcohol and Substance Abuse	2
Indian Health Services	2
Migrant Council	1

Number of Programs and Divisions. Knowledge related to the number of agencies involved in coordination paints only a partial picture of the scope of the coordination efforts. Each agency is composed of various subdivisions. These subdivisions may be called bureaus, branches, departments, or divisions depending upon the agency. As mentioned above, in most states there are four to six agencies

included in the coordination of services. However, the scope of coordination becomes broader when all of the relevant subdivisions or programs within each agency are included in the coordination of services. In order to better understand the scope of coordination, we asked respondents to identify the number of different divisions or programs within each agency, if these were involved in coordination.

The complexity of service coordination is dramatized when considering the number of programs/divisions involved within single agencies. We learned that within a single state, the number of programs ranged from a single program/division within one agency (e.g., the Department of Special Education within the Education Agency) to as many as 14 programs/divisions in another single agency (e.g., multiple programs within an umbrella agency such as Human Resources). When the number of subdivisions within the agencies were totaled for each state, the number of subdivisions participating in the coordination of services ranged from 1 in one state to as many as 34 subdivisions participating in another state. The mean number of programs or divisions involved, when data for all states was combined, was 10.35. Clearly, with the mean number of agencies, presents one picture of the scope of coordination. However, knowledge of the number of programs within those agencies involved in service coordination efforts presents an even broader picture of the scope of states efforts with regard to service coordination.

One state reported that only one agency and one program within that agency is involved in service coordination. It is difficult to imagine how this state is meeting either the letter or the intent of the law. By contrast, however, the number of agencies and subdivisions reported by most of the other states demonstrates that the states appear to be meeting both the letter, as well as the intent of the law.

Number of Agencies Providing Service. Another way to look at the scope of coordination is to have a better understanding of how many agencies are

involved in the coordination of each type of early intervention service, recognizing that some types of services may require more coordination than others.

Respondents were asked to indicate the number of agencies involved in various services. Table 6 presents the tabulations of the number of agencies reported by responding states to be involved in coordinating each service. Included are the minimum, maximum and mean number of agencies when data from all states are combined.

Table 6. Number of State Agencies Coordinating Services in Responding States

Type of Service	Minimum	Maximum	Mean
Public Awareness	1	11	3.5
Child Find	1	11	3.54
Service Directory	1	5	1.91
Screening	0	7	2.97
Diagnostic Assessment	1	7	2.79
IFSP	0	7	2.28
Family Counseling	1	4	2.25
Service Coordination	1	7	2.70
Developmental Intervention (cognitive, motor, language, etc.) Services	1	7	2.25
Occupational Therapy	0	7	2.28
Physical Therapy	0	7	2.25
Speech/Language Therapy	0	7	2.31
Audiological Services	1	7	2.21
Psychotherapy/Mental Health Services	0	3	1.60

We found that, on the average, three or four agencies were involved in child find and public awareness activities, which might be described as system entry, and considered by some to be easier and less costly because of the short term nature of interaction. In general, fewer agencies were involved in coordinating developmental intervention services, individualized planning, and therapeutic

services. Mental health interventions required coordination by the fewest number of states agencies, perhaps because the services were least commonly offered by many states.

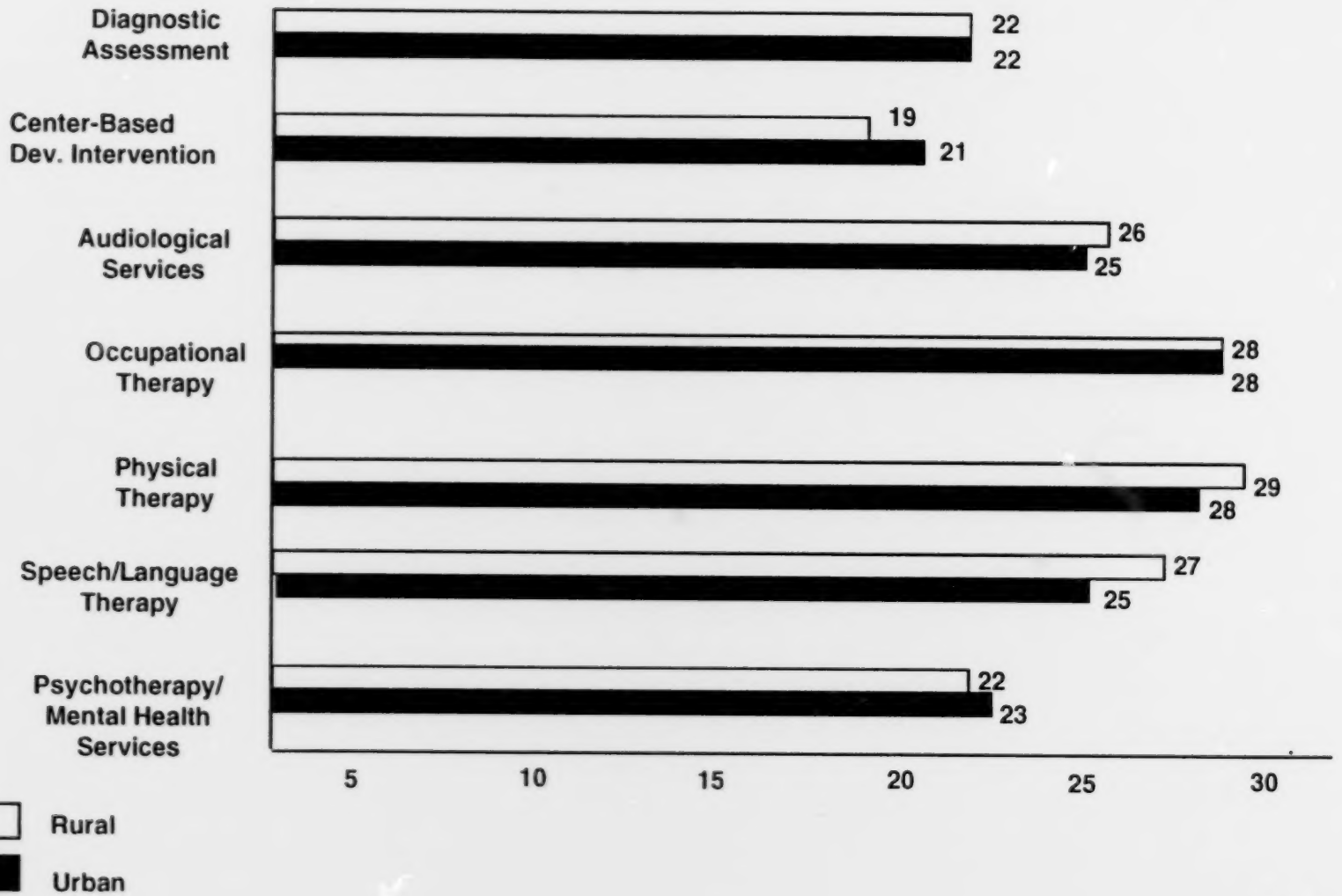
Use of Private Providers. While state agencies are responsible for the provision of services, case study results indicated that there were not a sufficient number of public providers, and thus, states and/or communities were likely to need to utilize private providers. Many individuals have raised concern about the lack of therapists in rural areas. Thus, we asked respondents about the use of private providers in both rural and urban areas. We thought states would indicate that they would be used more often in rural areas.

As seen from Figure 2, reliance on private providers failed to distinguish urban from rural areas. In both settings, physical and occupational therapy lead in utilizing the private sector for service provision. Over half of the respondents in the study called on the private sector for assessment and center-based intervention services, a reminder of the complexity and breadth of the service system for young children with special needs and their families.

Structures and Mechanisms Used for Coordination

Our case studies showed that agencies and programs were often set up as autonomous units (Harbin, Clifford, Gallagher, Eckland, & Place, 1991; Harbin & Terry, 1991). Case studies further indicated that if states were to be able to coordinate services across these autonomous units some type of administrative structure was needed to accomplish this task. In our case study states, this was achieved through the Interagency Coordinating Committee required under Part H, as well as by some other mechanisms created for policy development and coordination across agency and program lines of authority. In this study, we sought to establish

Figure 2
Use of Private Providers To Provide Early Intervention Services In Rural and Urban Areas



the role of lead agencies in fostering coordination, and to learn what mechanisms states were using for the purpose of service coordination.

Lead Agencies Role In The Approach To Decision-Making. Interagency policy planning has been described (Flynn and Harbin, 1987; Kagan, 1990) as a continuum with three levels: coordination, cooperation and collaboration. These levels are related to the issues of power and autonomy in decision-making.

The survey instrument offered respondents five choices which were based on the levels determined to exist within the six case study states (Harbin & Terry, 1990).

Table 7 shows the range of options provided to respondents, and the number of states selecting each decision-making approach.

Table 7. Decision-Making Approaches Of Responding States

Decision-making Approach	Number of States Selecting Option
No need for coordinating	2
Coordination occurs with individual agencies around individual issues (e.g., transition)	3
Lead Agency retains a great deal of decision-making authority, but seeks input from other agencies	10
Lead Agency provides management and financial support to coordinate activities, but all agencies participate relatively equally in decision-making	20
Interagency Unit is a legal entity within state government and all participate equally in decision-making	2

These findings indicated that the majority (30 of 37 states, or 81% of respondents) appear to be attempting to include multiple agencies in making major decisions concerning the design and operation of services.

While time consuming, such multiple agency involvement in decision-making and, therefore, empowerment is probably necessary in order to achieve the broad goals of coordinating the wide variety of programs, discussed earlier.

Use of Formal Liaisons Between Part H and Other Agencies. Case studies had indicated that in some states the ICC was considered insufficient to accomplish the task of coordination of services across agencies and sectors. Some states suggested that what was required was an individual who worked on Part H, but also was assigned to (or was based in) another relevant agency, in order to ensure the day to day coordination that is necessary.

We were interested to see how widespread was the use of this mechanism of coordination. We found that over 65% (25 of 38 responding states) had established formal liaison relationships to foster coordination.

We also asked to which agencies liaisons were assigned or located. As might be expected, the three most frequent responses were: Education, Health, and Human Resources.

Additional details of liaison location or assignment are shown on Table 8, which reports the number and percentage of responding states identifying each agency or service as the locale for liaison assignment. Interestingly, some respondents reported assignment of liaisons to programs other than state agencies. States appear to establish liaison first with major agencies, and only secondarily make assignments to specialty agencies (e.g., sensory impairment).

Table 8. Assignment Or Location of Liaison For Coordination

Agency	Number of States
Education	17 (68% of states using liaisons)
Health	14 (76% combined)
Health Related (EPSDT, MCH, Public Health)	5
Human Resources	10 (40%)
Developmental Disabilities Mental Retardation	6 (24%)
Mental Health	5 (20%
Medicaid	4 (16%)
Social Services	3 (12%)
Sensory Impairment	2 (8%)
Alcohol and Substance Abuse	2 (8%)
Rehabilitation Services	1 (4%)
DD Planning Council	2 (8%)
Head Start	1 (4%)
Child Development & Rehabilitation Center	1 (4%)
Program for Autistic Children	1 (4%)

Policy Group of Mid-level Managers. Case studies indicated that while liaisons were helpful in day to day activities of coordination that were carried out by program staff, this did not necessarily meet the need for policy agreement and coordination among those individuals with authority and responsibility for policy decisions for an entire division (e.g., Developmental Disabilities, Maternal and Child Health, or Special Education). If policies were to be coordinated and approved, it was critical for these program administrators to be included.

We were interested to see how widespread the use of such a Director L vel group was across the country. Our survey found that the majority of responding states, (78%, or 29 of 37) used such a group, while 22% (8 of 37) did not.

We explored whether the groups existence were formal or informal within the state government, and learned that of the 29 responding states with such a group, nineteen (68%) reported informal groups, nine (31%) were formal, and one respondent did not answer the question.

We compared lead agency types with respect to this question, and found some interesting differences. Health Department lead agencies were more likely to use formal groups or report no group. States in which Education and Human Resources are the lead agency tended to use informal groups more often.

Use of an Intra-Agency Work Group. Our case studies had indicated that some states had developed an intra-agency work group within at least one of the agencies that contained a large number of relevant programs. Such agencies were usually Health or Human Resources Departments.

We were interested to find out whether our survey states were using this mechanism. We found they did, with 26 states, or 70%, using an intra-agency group, and only 11 states not using one. According to the literature regarding decision-making (Terry, 1984), groups function more smoothly and effectively when members are generally equal in power, authority, and/or position. We thought it would be useful and interesting to learn about the composition of intra-agency work groups in responding states.

Table 9. Composition Of Intra-Agency Work Groups

Composition	Number of States
Director Level	3
Program Staff	13
Combination	14

For the most part, these groups are composed of a combination of program director and program level staff members and, also, frequently composed of program staff only. Some states indicated the existence of more than one type of intra-agency work group.

Local Lead Agency. We found in our case study states that the designation of the lead agency at the state level did not necessarily dictate the designation of the lead agency at the local level. Some case study states followed the example of the Congress and were allowing communities to select the lead agency that each community deemed most desirable given previous service delivery.

We were interested to see how widespread this practice was, and were surprised by our findings. Of the 25 respondents answering this question, seven states (28%) required the same lead agency at the local level, but fifteen state respondents (60%) permitted local selection. In three cases (12%), no lead agency was designated locally. This degree of flexibility was not expected.

Policies Related to Service Coordination

Case studies indicated that decisions and agreements needed to be formalized in some way. There were interagency agreements related to Part H that were jointly developed and signed by participants in service delivery to infants and toddlers with developmental delays, and their families. In addition, each agency and program has a set of its own policies, often related to other pieces of federal legislation (EPSDT, Programs for Children with Special Health Care Needs, etc.) and other target populations which overlap with the target population for Part H of the IDEA. We wanted to examine states efforts and approaches related to the coordination of policies for service provision.

Interagency Agreements. Part H of the IDEA requires states to develop an interagency agreement (PL 102-119, Sec. 1476, (b), (9), (F), 1991). It appears that Congress assumed that a formal agreement would be needed to ensure the on-going coordination of services across agencies. An earlier study (Harbin, Gallagher, & Lillie, 1990), in addition to case study results, indicated that states were approaching the development of interagency agreements in two different ways: (a)

development of a single agreement that would address all elements of the service system, and include all relevant agencies as signators; and (b) development of multiple interagency agreements addressing various aspects of the service system, with different signators to each agreement, based upon which agencies are to participate in each of the aspects of service delivery (e.g., transition).

The development of interagency agreements has been consistently one of the areas in which progress has been slowest (Harbin, Gallagher, & Lillie, 1989, 1991; Harbin, Gallagher, Lillie & Eckland, 1990; Harbin, Gallagher, & Batista, 1992). Therefore, earlier findings regarding the number of interagency agreements were based on those few states that had begun this process. We wanted to see how states were approaching this task, given that more time had elapsed.

The question, Has your state developed an interagency agreement(s)? , yielded 38 responses. Of these, four states had not yet developed an interagency agreement, and 34 (89.4%) had agreements in place. One respondent indicated that the nature of the State s legislation and structure obviated the need for agreements, but that it was likely that one or more would be developed, simply to comply with expectations of the Federal lead agency.

We were interested to know the number of state level interagency agreements. Results are specified in Table 10.

Table 10. Number Of Interagency Agreements In Responding States

Number of Agreements	Number of States
1	12
2	10
3	4
4	2
5	2
6	1
7	1
8	1
9	1
10	1

As is evident from the above, the majority of respondents have one or two state level agreements.

Number of Signatories. Respondents were asked to indicate how many agencies signed each interagency agreement. The range for the group of responding states was from a low of one signatory (in one state) to eleven signatories in another state. The mean number of signatories for all states combined was 3.77.

Status of local interagency agreements. Most services are delivered at the community level, and much has been said about the importance of local coordination (Harbin & Terry, 1991; Harbin & Van Horn, 1990; Intrilligator, 1990, Magrab & Elder, 1979; Swan & Morgan, 1993). We were interested to find out if communities were developing interagency agreements. From the perspective of our respondents, who were working at the state level, we inquired about the status of local interagency agreements.

Table 11. Status Of Local Interagency Agreements

Status	Number of States
No Local Agreements Exist	6
Local Agreements Required	9
Agreements Encouraged But Not Required	14
Agreements Allowed But Not Encouraged	4
Agreements Not Permitted	1

As the above data show, we found that most states were requiring or encouraging local agreements and were surprised to learn that interagency agreements were actually prohibited in one state.

It would be interesting to know what percentage of the communities in those states actually had formal interagency agreements, but this question was not within the scope of the present study.

Effect of Part H on Policies for Other Related Programs. Logic dictates that the task of coordination would be easier if policies across various state and federal programs were identical or at least similar. Many state policymakers had complained that disparate federal policies create a barrier to coordinated policy development (Harbin & McNulty, 1990). Some federal programs have made revisions in their policies, making them somewhat more compatible with Part H of the IDEA.

We were interested to see if Part H policy development at the state level had an effect upon policy development or revision of the policies for the other major programs (EPSDT, Children s Medical Services, etc.). Respondents were asked to select the item which best described the general situation with regard to how the policies of other state programs were being affected. If none of the choices provided in the survey accurately described the situation, respondents were given the option

of writing their own response. There were 3 respondents that selected the other response. In general, all three respondents indicated that it was too early to determine the effects upon other programs policies. The following table presents the responses to this survey question.

We were surprised to find that more than half of responding states (57%) reported that agencies were changing their policies to complement Part H. Three respondents indicated that the answer varied by program.

One respondent wrote: "This is difficult to answer. The question seems to assume that Part H is of such high priority that it drives the policies of other programs. In many cases we have more opportunity and flexibility in developing Part H policies that allow us to access other programs. Perhaps another choice is needed here."

Table 12. Effect Of Part H On Policies For Other Programs

Affect on Other Policies	Number of States
Other Programs Are Changing Their Policies to be Identical With Part H Policies	2
Other Programs are Changing Their Policies to be Complementary With (but not identical to) Part H	20
Other Programs Are Using Part H Policies and Procedures Only for Part H Eligible Children	8
Other Programs making no change in policies	4
State Is Not Coordinating With Other Programs	1

While it appears that some states see the task as one of trying to integrate Part H into an existing system, other states view the situation differently. Policymakers in some case study states saw the passage of Part H of the IDEA as the impetus that was needed to reform policies, and hence, services for all infants, toddlers and their

families. These policymakers viewed this as an opportunity to make changes that brought their systems more in line with the knowledge of child growth and development, reflected in the current literature.

These survey data corroborate other indications that many states are using a participatory approach to the development of Part H policies, and support the finding that participating in Part H planning and decisionmaking has had an impact on the policies of related programs.

Organizational development studies (Miles, 1980) indicate that when work spans organizational boundaries, these activities can be highly satisfying and productive, provided that conflicts can be resolved. The high percentage of states reporting such boundary spanning activities as the extensive use of liaisons (66% of responding states), wide use of a Director level policy group (78%); and the use of an intra-agency work group (68%) suggests that the work of these groups went beyond work to develop Part H policies only, and actually worked to change other related program policies as well.

Role of Private Health Sector. For the most part, policies are developed for public services. The provision of services to young delayed and vulnerable children, however, is not limited only to the public sector. The private sector plays a significant role in the provision of services. As discussed earlier in the results section and presented in Figure 2, many states intend to use private providers in both rural and urban areas in order to provide a full range of early intervention services (Fullagar, Croster, Gallagher, & Loda, 1993; Gallagher & Fullagar, 1992). In addition, private physicians provide on-going health care to many young children. It is often the physician who is in the best position to recognize that a child potentially needs early intervention. Thus, their knowledge of the existence of such services, and how to assist families in accessing services, is critical if early identification is to become accomplished.

Therefore, we were interested to find out to what extent this important group had been included in the development of the very policies that they would be requested to implement.

We asked respondents to indicate on a continuum (none, minimal, moderate, extensive) the amount of involvement of various private health entities in planning and policy development. Findings are shown in Table 13, which reports the number of states that reported participation levels ranging from none to extensive for various private health sector groups.

According to survey respondents, the private health sector was not extensively involved in planning and policy development for the system of early intervention services. However, when we clustered responses that indicated moderate to

Table 13. Participation Level of Various Private Health Entities In Part H Coordination, By State

Private Health Entity	Number of States at Each Level of Participation			
	None	Minimum	Moderate	Extensive
Hospitals	5	19	10	4
Private Clinics	11	22	4	1
Individual Pediatricians	0	15	19	4
Ind. Child Psychiatrists	16	17	2	2
Ind. Family Practitioners	8	19	10	1
Pediatric Rehab. Centers	8	11	11	7
HMOs	14	15	6	2
Home Health Agencies	9	17	10	2
Neonatal Follow-up Clinic	0	0	0	1
Neonatologist	0	0	1	0

extensive involvement of the various private health sector entities, we found that individual pediatricians and pediatric rehabilitation centers were considered more involved than other health entities from the private sector. Least involved were child

psychiatrists; 89% of responding states reported no or minimal involvement of that private sector discipline.

We rank ordered the health sector group from the most to least involvement, by calculating the percentages of responding states that indicated either moderate or extensive involvement. Results are shown in Table 14.

Two respondents indicated that their early intervention systems were locally driven. One respondent completed the survey based on state involvement, but implied that responses would be different from the local perspective. It is conceivable that if this question were asked of community providers, answers would vary considerably across localities.

Table 14: Rank Order Involvement In Part H Of Private Health Entities, Based On % Of Responding States Rating Involvement As Moderate Or Extensive

Private Health Entities	% of States Selecting Moderate to Extensive Involvement
Individual Pediatricians	60.5%
Pediatric Rehabilitation Centers	48.6%
Hospitals	36.6%
Home Health Agencies	31.6%
Individual Family Practitioners	28.9%
HMOs	21.6%
Private Clinics	13.1%
Individual Child Psychiatrists	10.8%

Number of Individuals Officially Designated to Work on Part H Activities

The development of a coordinated comprehensive service system as required by Part H of the IDEA is quite an enormous undertaking. Survey results have indicated that states are taking this charge from the federal government seriously. Most have chosen a large scope effort for coordination, with moderate to extensive participation by other agencies.

Case study results, as well as the literature, on service coordination (Harbin & McNulty, 1990; Harbin & Terry, 1990) indicate that human resources (people and

their time) are needed if coordination is to be successful. We were interested to find out how many people were working on the tasks, necessary to ensure service coordination. We were curious to determine whether they were assigned to Part H work on a full time or part time basis.

Across the 38 responding states, there were a total of 206 full time staff, some funded by state or federal sources other than Part H funds. There were also a total of 57 (27.6%) part time staff members. We were surprised that part time staff were relatively uncommon. We expected that many of the individuals serving as liaisons to Part H from other agencies might have responsibilities for other tasks and activities within their agencies in addition to Part H. These individuals would then be considered part time employees. However, it appears that the duties of those individuals working on Part H are sufficient enough to require full time effort.

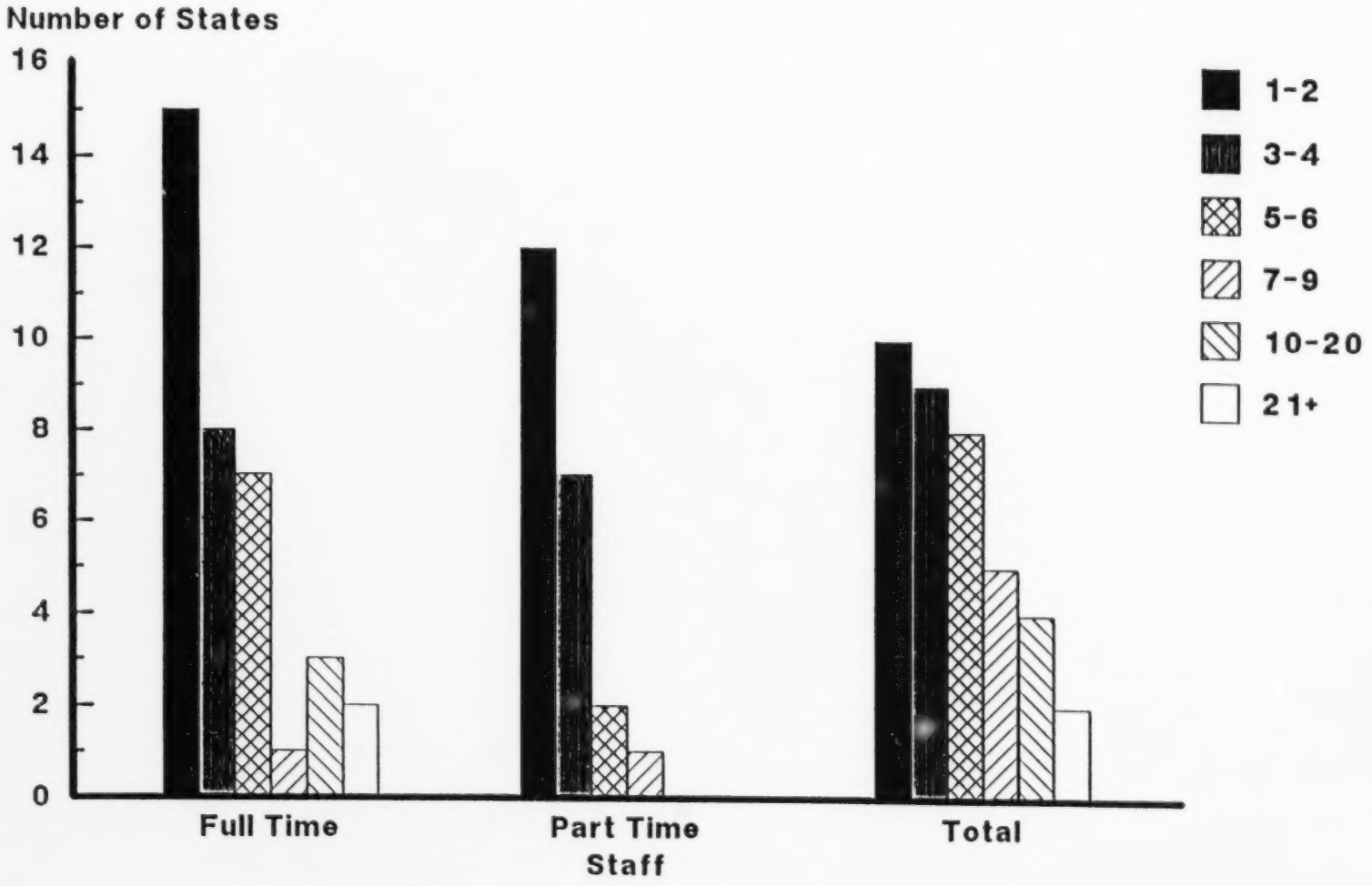
Since we did not ask about position vacancies, the numbers of personnel in positions may underestimate numbers of actual positions. In fact, one respondent volunteered the comment that, in addition to the staff reported, there were two vacant positions in that particular state.

Of the 38 responding states, 36 (94.7%) indicated that at least one person was assigned to work full time on Part H activities. Of these states, 20 also reported using part time staff.

The size of the staff varied considerably across states. Twenty seven of the 38 responding states (71.1%) reported a staff of six or fewer. Two states reported a staff or over twenty individuals. The mean number of full time staff was 5.7, and the mean number of part time staff was 2.6. Figure 3 visually presents the number of full and part time staff assigned to Part H activities.

Financial Support for Staff. In case studies we learned that in some states only a portion of the individuals working on Part H were paid with Part H funds. Some were paid using state funds or other federal program funds. For example, a

FIGURE 3: Staff for Part H Activities



Taken from Clifford, R., Bernier, K., & Harbin, G. (1993)

participating agency would assign a staff member to work on Part H activities on behalf of that agency.

Funding for the individual might come from state Developmental Disabilities Funds, or from federal program funds such as the Maternal and Child Health Block Grant, Program for Children With Special Health Care Needs, or Special Education Preschool funds. This is not an inconsequential contribution, and evidences an extraordinary commitment to services for the eligible population by collaborating agencies. Additional financial considerations suggested by these data are reported elsewhere (Clifford, Bernier and Harbin, 1993).

Accomplishments in the Area of Service Coordination

Coordination is a time-consuming and difficult process. Much time usually elapses between the initiation of coordinated planning and actual implementation. Moreover, results of coordination efforts are complex and difficult to measure, particularly when expected, tangible outcomes vary from one stakeholder to another. We were interested to learn whether states saw progress being made related to the coordination of services and in what areas.

We found that in 24 of 38 responding states (63%), some type of improvement in the coordination of services was reported. There were 13 areas of progress. Four of these 13 areas are related to system entry or early identification and include: Child Find (5 states), Public Awareness (3 states) Screening (2 states), and Diagnostic Assessment (3 states). In one State, the respondent said There have been significant improvements in public awareness and early identification based on (the increased) numbers of children entering (the) system.

A second prominent area of change relates to the existence of a more positive attitude toward coordination, including increased participation of, and communication among, agencies and programs. For example, respondents in four

states identified progress in bringing public, private and parent advocacy groups to participate in a dynamic process.

From the perspective of State Part H Coordinators who responded to this survey, other tangible areas of improvement included:

1) general improvement in coordination at the local level (8)
2) connections with the public and private health sectors (5)
3) commitment to family-focused rather than child-centered programs and development of IFSPs (2)
4) case management or service coordination (2)
5) transitions from hospitals and to public schools (2)
6) development of interagency agreements (2)
7) tracking of at risk children (2)
8) staff development (1)
9) coordinated data collection concerning child characteristics or services received (1)

State Evaluation of Service Coordination Efforts

Given the difficulties in evaluation of interagency coordination due to the lack of models, as well as obtaining the time and resources to undertake such as evaluation, we were surprised to find that respondents in 17 states indicated that they were systematically studying service coordination at the state or local level or both.

A qualified response from one of the states seemed to reflect the incipient status of service coordination evaluations. This statement, ... (we are) collecting data more systematically than ever before, but not really in a systematic, research oriented manner, suggested to us that routine evaluation studies are more of an aspiration than a reality.

Since the questions we asked focused on whether, but not how, progress in coordination of services was being studied, responses did not allow us to learn much about the scope to these current evaluation efforts, or even to know whether states are focusing on evaluating the process, or the outcome, of their service coordination efforts.

SUMMARY AND CONCLUSIONS

Given the documented barriers to the successful coordination of services, along with the widespread skepticism regarding its feasibility, it is imperative to better understand how this critical linchpin of Part H of the IDEA is being implemented across the country. Reforming the very structures of the service delivery system is certainly no simple task. Therefore, information regarding this major reform effort is of importance to federal, state and local policymakers, as well as those who provide and receive services.

The purpose of this study was to describe both the nature and scope of the service coordination efforts as a result of state s participation in this monumental legislation. To that end, we examined the breadth of the goals for coordination, the scope of the target population to be served, as well as the number of state agencies and subdivisions participating in service coordination efforts. In addition, we examined the extent of participation of the private sector in planning and policy development, as well as in service provision.

In order to gain knowledge regarding the nature of coordination, we examined the various structures and mechanisms used by states to accomplish their coordination goals. The development of interagency agreements, in addition to the relationship between Part H policies and those of other programs were also described. Finally, we addressed who was instrumental in developing the vision for this coordinated system of early intervention services, and the number of individuals

contributing full and part time effort to the realization of coordinated services at the state level.

Principal findings from this study attest to the widespread commitment of personnel in agencies throughout the country in implementing Part H of the IDEA. This study showed that goals and activities for coordination under Part H of the IDEA have been broad, involving many agencies, programs and providers in the public and private sectors. In fact, even as definitions of eligibility for Part H have narrowed in some states, the focus of coordination has extended beyond developmentally delayed infants and toddlers and have included at risk populations, excluded in the same states from entitlement to services under the law. In some states, the vision for coordinated services is restricted to include a few agencies and a confined population of eligible infants and toddlers, but our survey affirmed that, more commonly, the goals for coordination reach well beyond the services made available to the eligible population under Part H, as states seek to relate Part H to broader initiatives.

This breadth of concern for children and families seems an appropriate and beneficial endeavor for the children and families that Part H of the IDEA is designed to serve. As the nation turns greater attention to the importance of the earliest years of life, higher visibility is increasingly given to early childhood programs at all levels of government, as well as in the private sector. Emerging programs that are not necessarily designed for children with disabilities, such as family support centers and parent literacy initiatives, connected through coordination efforts to Part H, will help states to develop services that are truly comprehensive for all children.

In general, our findings yielded a sense that Part H is moving ahead aggressively in facilitating interagency communication and fostering better coordinated services. Within the spectrum of a service system, it is easier to identify children through public awareness and child find than to conduct complex

multidisciplinary assessments, and in turn, assessments are easier to achieve than long term, ongoing interventions. We would have been surprised had we found coordination among agencies to be centered largely around intervention. Predictably, we learned that interagency coordination efforts tended to be targeted to systems entry activities. These findings indicate that perhaps agencies should examine the need to reallocate some resources from child find and individual assessments to service provision. Parents have long complained that their children have been found and assessed many times, but then are unable to receive the necessary scope or intensity of services, due to the lack of resources (Harbin & McNulty, 1990). It will take pressure to reverse the tendency of agencies to focus on aspects of the system that require the least investment.

Predictably, as a result of the large scope of the coordination efforts and in an attempt to build bridges across the normal partitions of state government, states reported utilizing a variety of multi-leveled structures to facilitate the coordination of services. States often saw the need to utilize a group of Program Director level administrators, as well as utilizing program staff to serve as liaisons between Part H activities and the various activities of other relevant programs.

Also related to the scope of coordination, was the discovery concerning the number of state level interagency agreements that had been developed. The fact that so many agreements have been developed in such a relatively short time frame is remarkable. However, now we must turn our attention to the nature of these formal agreements in order to determine if they are meaningful instruments which guide and ensure the coordination of early intervention services.

Results that are among the most fascinating are those that are unexpected. Because our survey was based on findings from prior case studies, we were able to predict many of our findings and had relatively few surprises.

One surprise was the amount of collective vision setting that was reported, with most states crediting multiple groups for their leadership. This may simply reflect our other finding, that many agencies are significantly invested, and have been sufficiently empowered that program ownership is shared.

Since we asked specifically for identification of a sole leader, we had expected to be able to identify one, or at most two, visionary leaders who were singled out for their accomplishments in setting the vision. Studies of the communication of innovations (Rogers, 1983) show that change, plotted over time, follows a bell shaped curve. It is accepted initially by a few, reaches a peak, and finally, as later conformers join, the innovation then loses its appeal to the earliest supporters, as new ideas capture their interest. It might be speculated that we were studying Part H of the IDEA at the time of general acceptance, when individuals who bought into the program early were so well identified with the program as to be credited with its leadership. It is also possible that turnover in personnel has necessitated sharing leadership, because to do otherwise would risk failure when one leader moves on.

In addition, this finding may be consistent with an earlier finding from the case studies indicating that due to the multi-agency, multi-sector nature of the legislation, implementation was most successful when there was a small core group of leaders setting the vision for the coordinated system. However, these same case studies also found that one to two individuals within the lead agency actually provided leadership to this "leadership group." As mentioned in the Results section of this paper, it may be out of modesty and/or political sensitivity that respondents failed to designate the leader of the leaders.

We also were surprised by the extent of the public sector s reliance on the private sector for assessment and intervention services, particularly in rural settings.

We found no distinction between urban and rural in this respect, and concluded that the shortage of publicly supported personnel may be a universal problem.

One of the most unexpected findings related to the effect of Part H policy development upon the various policies of other relevant programs (e.g., EPSDT, WIC, CSHCN, etc). It was surprising to discover that over half of the responding states (57%) reported that other agencies and programs were actually changing their policies to be more complementary with Part H early intervention policies. Indeed, there were 2 states reporting that these other programs were changing their policies to be identical to Part H policies. This seems to indicate that the framers of Part H of the IDEA, who sought to establish legislation that reflected what was recognized as state-of-the-art in the early intervention literature, have also had a tremendous impact on the policies of other relevant programs. It appears that in many states Part H policy development has been a stimulus and created an opportunity to bring the policies for many children s programs more in line with what is known about intervening effectively with children and their families.

We had some unanticipated findings around the way services are coordinated locally. It was surprising to note how much flexibility was afforded to local communities in choosing their lead agencies. Designation as a lead agency carries an element of prestige and power. Moreover, transfer of funds from the state to the municipality is sometimes involved. Hence, it is reasonable to expect that a State Department of Education would insist that a Local Education Agency would be designated as the local lead agency, that a State Health Department might demand that its local counterpart would have authority and accountability, and so forth. We found, however, that there was considerable flexibility around local lead agency choice. Just as the Federal Statue gave the Governor the option of selecting the lead agency at the state level, the State lead agency in many cases has respected local differences and need for locally driven coordination efforts.

A second area of flexibility pertains to local interagency agreement development. As one might expect, many states are encouraging local agreements, and some were generated at the grassroots level even prior to the state's involvement in Part H of the IDEA. We would expect this to continue, since local interagency work will be the bulwark of Part H implementation. For this reason, we were surprised to find one state that not only failed to encourage local interagency agreements; it actually prohibited them. A regulation that prohibits formal agreements among agencies presents a message that is contrary to the intent of this legislation. The coordination of services is likely to be an uphill battle in this state.

Finally, we were surprised by the extent of self-assessment that has occurred. The scarcity of financial resources always influences a state agency s willingness to conduct evaluation efforts to any kind. Decisions are often made to utilize these scarce resources on intervention services, since there never seems to be sufficient funding to provide all needed services to all children and families who need them. When evaluation efforts occur, they are usually tied to federal reporting requirements and focus upon the number of children served, number of services provided, etc. Evaluation of interagency coordination of service delivery is a much more complex undertaking, than the usual traditional compliance - oriented evaluations. Therefore, it is surprising that states were willing to over-come the multiple barriers related to this type of evaluation. These barriers include: lack of fiscal resources; apathy and lack of the willing cooperation of agency administrators and program staff; lack of time; and lack of sufficient system-oriented, multi-dimensional evaluation models. Policymakers in states who are undertaking this formidable task should be commended. However, only time and further examination of these efforts will enable us to determine their usefulness.

It will be encouraging for child advocates and other stakeholders in the Part H program to learn that there have been a great many tangible results related to the

coordination of early intervention. Most prominently cited were general improvements in coordination at the local level and connections with both the public and private health sectors. The other areas of improvement that were cited, including commitment to case management and family-focused rather than child-centered programs, the development of individualized family service plans (IFSP) across agencies, transitions from hospitals to early intervention, and from early intervention to schools, interagency agreements, tracking systems for at risk children, staff development and data collection concerning children, seem to be, in and of themselves, worthy of the investment in coordination efforts.

Some of these tangible benefits ultimately will be measurable in child and family outcomes. Others are not. One of the difficulties of system reform is that changes and improvements in processes are more readily measured than changes and improvements in the status of children and their families. Results of this survey tell us from a process standpoint that changes in coordination have had favorable outcomes. Future studies are needed to determine whether these effects are enduring and whether there has been an impact on child and family outcomes.

However, for the present, it seems that there is at least a partial answer to the question posed by Peterson in the introduction to this paper. Peterson wondered ... can workable interagency systems be planned, organized, and fully implemented in a short period and still enable collaboration to be successful and operable in the future? Findings from this study indicate that state policymakers, parents, and providers have made substantial progress in meeting the letter and intent of the federal legislation, as they have developed broad-based, comprehensive approaches to service coordination.

SELECTED REFERENCES

Brewer, G. and Kakalik, J. (1979). Handicapped children: Strategies for improving services. New York: McGraw Hill.

Christensen, M. (1982). Interagency collaboration in Virginia: Service for the handicapped learner. Dissertation Abstracts International, 43 (4) 0247.

Clifford, R., Harbin, G. and Bernier, K. (1992). Preliminary findings: Coordinating services and financing for Part H of IDEA.

Clifford, R.M., Bernier, K.Y., and Harbin, G.L. (1993). Financing Part H Services: A State Level View. Chapel Hill, NC: Carolina Policy Studies Program.

Colby, C.R. (1987). Cooperation among agencies serving individuals with disabilities. Dissertation Abstracts International, 47: 4369.

Dillman, D.A. (1978). Mail and telephone surveys: The total design method. New York: John Wiley & Sons.

Flynn, C.C. and Harbin, G.L. (1987). Evaluating interagency coordination efforts using a multidimensional interactional, developmental paradigm. Remedial and Special Education, 8 (3) 35-44.

Fullagar, P.K., Crotser, C., Gallagher,k J., & Loda, F. (1993). Communication, coordination, and cooperation: Perspectives on service delivery and Part H. Carolina Policy Studies Program, Frank Porter Graham Child Development Center. Chapel Hill, NC: University of North Carolina at Chapel Hill.

Gallagher, J. & Fullagar, P. (Eds.) (1992). Health and other services for infants and toddlers with disabilities: The Conundrum of parallel systems. Carolina Policy Studies Program, Frank Porter Graham Child Development Center. Chapel Hill, NC: University of North Carolina at Chapel Hill.

Gans, S.P. and Horton, G.T. (1975). Integration of human services: The state and municipal levels. New York: Praeger.

Harbin, G. and Terry, D. (1991). Interagency service coordination: Initial findings from six states. Chapel Hill, NC: Carolina Policy Studies Program.

Harbin, G. and Van Horn, J. (1990). Interagency coordinating council roles and responsibilities. Chapel Hill, NC: Carolina Policy Studies Program.

Harbin, G., Clifford, R., Gallagher, J., Eckland, J., and Place, P. (1991). Technical report: Case study methodology for studying the implementation of P.L. 99-457, Part H. Chapel Hill, NC: Carolina Policy Studies Program.

Harbin, G., Gallagher, J., and Lillie, T. (1989). States progress related to fourteen components of PL 99-457, Part H. Chapel Hill, NC: Carolina Policy Studies Program.

Harbin, G., Gallagher, J., and Lillie, T. (1990). Factors influencing progress in legislative implementation of Part H of P.L. 99-457 (Infants and toddlers with special needs legislation). Chapel Hill, NC: Carolina Policy Studies Program.

Harbin, G., Gallagher, J., and Lillie, T. (1991). Status of states' progress in implementing Part H of IDEA: Report #3. Chapel Hill, NC: Carolina Policy Studies Program.

Harbin, G., Gallagher, J., Lillie, T. and Eckland, J., (1990). Status of states' progress in implementing Part H of P.L. 99-457: Report #2. Chapel Hill, NC: Carolina Policy Studies Program.

Harbin, G.L. and McNulty, B. (1990). Policy implementation: Perspectives on service coordination and integrating cooperation. In Meisels, S.J. and Shonkoff, J.P. (Eds.) Handbook of early childhood intervention. New York: Cambridge University Press.

Harbin, G.L. and Terry, D.V. (1990). Definition of developmentally delayed and at-risk infants and toddlers. Chapel Hill, NC: Carolina Policy Studies Program.

Harbin, G.L., Gallagher, J., and Batista, L. (1992). Status of states' progress in implementing Part H of IDEA: Report #4. Chapel Hill, NC: Carolina Policy Studies Program.

Hayes, C.D., Ed. (1982). Making policies for children: A study of the federal process. Washington, DC: National Academy Press.

Intrilligator, B., (1990). Community implementation: Planning activities in local Part H jurisdictions. Early Childhood Reporter, 1 (4). Horsham, PA: LRP Publications.

Kagan, S. 1991. United we stand: Collaboration for child care and early education services, NY: Teachers College Press.

Kagan, S.L. (1990). Field guide for the study of collaboration in early care and education. Unpublished manuscript.

Leach, J.A. and Barnard, U.S. (1983). A study of cooperation/ collaboration among employment training systems in Illinois. Urbana, IL: Department of Vocational and Technical Education, Illinois University.

Magrab, P.R. and Elder, J.O. (Eds.) (1979). Planning for services to handicapped persons. Baltimore: Paul H. Brookes.

Martinson, M.C. (1982). Interagency services: A new era for an old idea. Exceptional Children, 48 (5) 389-394.

Meisels, S.J., Harbin, G., Modigliani, K., and Olson, K. (1988). Formulating optimal state early childhood intervention policies. Exceptional Children, 55 (2) 159-165.

Miles, R. (1980). Organizational boundary roles. In Cooper, C. and Payne, R. (Eds.) Current concerns in occupational stress. NY: Wiley and Sons.

Peterson, N.L. (1991). Interagency collaboration under Part H: The key to comprehensive, multidisciplinary, coordinated infant/toddler intervention services. Journal of Early Intervention, 15 (1) 89-105.

Pollard, A., Hall, H., and Keeran, C. (1979). Community service planning. In Magrab, P.R. and Elder, J.O. (Eds.) Planning for services to handicapped persons. Baltimore: Paul H. Brookes.

Rogers, E. (1983). Diffusion of innovations, (3rd Ed.). NY: Free Press.

Steiner, G.Y. (1976). The children's cause. Washington, DC: Brookings Institute.

Swan, W.W. and Morgan, J.L. (1993). Collaborating for comprehensive services for young children and their families. Baltimore: Paul H. Brookes.

Terry, R.T. (1984). Interorganizational arrangement: An analysis of intreagency collaboration among public and private human services organizations in the District of Columbia. (Doctoral Dissertation, University of Maryland, 1983). Dissertation Abstracts International, 45:3259.

Weiss, J.A. (1981). Substance vs. symbol in administrative reform: The case of human services coordination. Policy Analysis, 7: 21-45.

Frank Porter Graham
Child Development Center
CB No. 8040, 300 NCNB Plaza
Chapel Hill, NC 27599